Parent Connection

A Parent to Parent Network of Alabama
CHILDREN'S REHABILITATION SERVICE
602 S. Lawrence St., Montgomery, AL 36104 TEL: 1-800-846-3697
Connecting families of children with special health care needs across Alabama to provide support, information, and training

Please match me with an experienced parent:
Yes_____ No_____

Willing to provide support to others?
Yes_____ No_____

PLEASE ONLY SHARE INFORMATION THAT YOU FEEL IS RELEVANT IN BEING MATCHED WITH OTHER PARENTS

FAMILY INFORMATION: First Name_____Last Name_____

Mailing Address_____

Street Address_____

City_____State_____ZIP_____County_____

Home Phone_____Work Phone_____Email_____FAX_____

Race_____African American_____Caucasian_____Hispanic_____Native American_____Asian_____Other **DOB**_____

Last Grade Completed _____Degrees or Certification_____Occupation_____

Marital Status ____Married _____Single_____Widowed_____Divorced_____Separated____Remarried

Relation to Child_____Mother_____Father____Birth____Foster___Adopted____Sibling____Grandparent___Other

Personal Experience/Interest (Check all that apply)____Advocacy___Inclusion____Independent Living ___Promoting Legislation___Public Policymaking____Speaking_____Starting or Maintaining Parent Support Group____Supported Employ. _____Training___Transition to Work

Organizations(Check all that apply) ___Arc__CRS Local PAC ____DCC ____Disability Specfic Organization ____Friends For Life ____Partners in Policymaking _____PTA _____Parent Support Group _____TAP Other_____

CHILD(REN) WITH SPECIAL NEEDS: First Name(s)_____Last Name_____

DOB_____Male___Female___**Disability was diagnosed**____Before Birth____At Birth____At the age of_____

Primary Disability or Condition:_____ADD/ADHA_____Autism_____Cerebral Palsy_____Cleft Lip/Palate _____Down Syndrome_____FragileX_____Genetic Disorder_____Hearing Impaired/Deaf _____Multiple Disabilities_____Neurologic Disorder_____Seizure Disorder_____Spina Bifida ____Visual Impairment/Blind____Other_____

REV 10/16/01

Please circle all items that best describe your child:

Assistive Technology
Augmentative Communication
Computer

Behavior
Aggressive
Overactive
Typical for Age
Underactive

Diet
_____
_____

Hearing
Cochlear Implant
Hearing Aid
No Hearing/Deaf
Partial Hearing Loss
Typical Hearing

Medications(list)
_____
_____
_____
_____

Type of School Program
Early Intervention
Home Schooling
Not Attending School
Public School
Private School
Resource Room
Regular Classes
Self-Contained Class
Special Education –Preschool
Speciallized Child Care

Feeding Skills
Fed by Others
Feeding Problems
Feeding Tube
Gastrostomy Tube
No Help Needed
Regular Diet
Some Help Needed

Toilet Skills
Catheterization
Help Needed with Toileting
Typical Toileting for Age
Not Toilet Trained

Speech
Clear and Understandable
Delayed Speech
Difficult to Understand
No Communication
Non-verbal Communication
Sign Language

Mobility
Crawls/Scoots
Delayed Mobility
Wheelcahir-Needs Assistance
Wheelchair-Self Operated
Typical Mobility for Age
Walks with Supportive Device
Walks Independently

Special Procedure
Colostomy
ECMO
Gastrostomy
Shunt
Tracheotomy

Vision
Contact Lenses
Corrective Lenses
No Vision /Blind
Typical Vision
Partial Sight Loss

Special Medical Equipment
Apnea Moniter
Heart Monitor
I.V.
Oxygen
Suction
Ventilator
Other_____

Treatments
Auditory Training
Chemotherapy
Lovass Therapy
Occupational Therapy
Patterning
Physical Therapy
Radiation Therapy
Speech Therapy
Vision Therapy
Other_____

List any surgeries related to your child's disability:_____

Where do you go for medical care?_____

Do you have insurance?____Yes____No_____**What Type?**_____
SSI?_____Yes_____No **Medicaid?**____Yes_____No **CRS?**_____Yes_____No **VR?** ____Yes____No

Does this child live at home? ___Yes___No___If not, where?_____
Other Children?____Yes____No Names and ages:_____

Extra notes:_____

` **I give my permission for my name and telephone number to be released to another parent.**

_____ _____
Signature Date